Subpart C—Claims for Payment

§ 424.30 Scope.

This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP). Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in subpart E of this part.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by HCFA in accordance with HCFA instructions.

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM, and a claim for physician services furnished to an SNF resident under § 411.15(p)(2) of this chapter must also include the SNF's Medicare provider number.

(3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with § 424.36(b)).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) A Part B claim filed by an SNF must include appropriate HCPCS coding.

(b) The prescribed forms for claims are the following:

HCFA–1450—Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

HCFA–1490S—Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

HCFA–1490U—Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)

HCFA–1491—Request for Medicare Payment-Ambulance. (For use by an organization requesting payment for ambulance services.)

HCFA–1500—Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

HCFA–1660—Request for Information-Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) *Where claims forms are available.* Excluding forms HCFA–1450 and HCFA–1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The HCFA–1450 and HCFA–1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from HCFA or any Social Security branch or district office, or from Medicare intermediaries or carriers. The HCFA–1490S is also available at local Social Security Offices.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998]

§ 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.

All claims for services of providers and all claims by suppliers and nonparticipating hospitals must be—

(a) Filed by the provider, supplier, or hospital; and

(b) Signed by the provider, supplier, or hospital unless HCFA instructions waive this requirement.

§ 424.34 Additional requirements: Beneficiary's claim for direct payment.

(a) *Basic rule.* A beneficiary's claim for direct payment for services furnished by a supplier, or by a nonparticipating hospital that has not elected to claim payment for emergency services, must include an itemized bill or a ''report of services'', as specified in paragraphs (b) and (c) of this section.

(b) *Itemized bill from the hospital or supplier.* The itemized bill for the services, which may be receipted or unpaid, must include all of the following information:

(1) The name and address of—